Application for Treatment Funds

Nebraska's Medicaid Treatment Bill (LB677) passed during the 2001 legislative session. It's effective date was September 1, 2001. Only those women diagnosed through EWM, after September 1, 2001, are eligible for treatment through Medicaid. This is great news for providers and the women they serve through the EWM program. This means that the majority of women screened in the EWM program and diagnosed with cancer of the breast or pre-cancer or invasive cancer of the cervix will be eligible for Medicaid coverage. Women entering Medicaid are eligible for coverage for the duration of their treatment.

How do Women Qualify for Medicaid Treatment Option

- Diagnosed with cancer of the breast or pre-cancer or invasive cancer of the cervix through EWM
- Uninsured
- Legal U.S. resident
- Nebraska state resident
- All women may be subject to income verification by EWM program staff

How to Apply for Medicaid

Healthcare Provider/Clinic Staff:

1. Complete the Treatment Funds Request form (see page 8-3)
2. Complete the Breast or Cervical Diagnostic Enrollment/Follow Up and Treatment Plan form
3. Provide copy of Pathology Report
4. Client must provide a copy of photo ID and birth certificate, if client born outside of Nebraska. Client must provide a copy of citizenship or naturalization papers (green card), if client born outside of US
   Nebraska or US - citizenship or natralization papers (green card) are required
5. Fax or mail all forms to EWM, Attn: EWM Program Representative
6. Provider setting up procedure needs to make sure they or the provider referring to is a Medicaid provider
7. All EWM documentation must be submitted (Breast or Cervical Diagnostic Enrollment/Follow Up and Treatment Plan form, Pathology Report, Treatment Funds Request form) by the clinic
8. Call EWM if you have questions at: 1-800-532-2227 or fax to: 1-402-471-0913

Client:

1. Provide information to EWM staff during the interview for the Breast and Cervical Cancer Medicaid Supplement form
2. Provide information to the clinic
3. Sign and date the Breast and Cervical Cancer Medicaid Supplement form
4. Client must provide a copy of photo ID and birth certificate, if client born outside of Nebraska. Client must provide a copy of citizenship or naturalization papers (green card), if client born outside of US
5. Client can complete this information while at the healthcare provider's office and the forms can be submitted via fax.

This is a collaborative effort between the clinic, client and EWM central office. Please call EWM 1-800-532-2227 with questions.

Treatment Resources for Women Ineligible for Medicaid

Program case managers will work with providers to find treatment resources for which clients may be eligible for.

Criteria:

- Diagnosed with cancer of the breast or pre-cancer or invasive cancer of the cervix through EWM
- Insured
- Not a legal U.S. resident
- Out of state resident - will be referred to Medicaid services of the state in which they have residency
- All women may be subject to income verification by EWM program staff to determine most appropriate treatment resource.

Treatment Resources

- EWM Foundation - Cap set based on available funds. Clients can only access funds once per lifetime per cancer diagnosis. Funding is limited and not guaranteed.

- AVON - Clients must access by calling 1-800-813-4673.

- Patient Advocate Foundation (PAF) (800)532-5274 - see Staff & Resources Section for more information

Steps to follow:

1. Complete the Treatment Funds Request form (see page 8-3)
2. Complete the Breast or Cervical Diagnostic Enrollment/Follow Up and Treatment Plan form
3. Provide copy of Pathology Report
4. Ask client for a photo identification and birth certificate if not born in Nebraska.
5. Fax or mail both forms to EWM, Attn: EWM Program Representative
6. All EWM documentation must be submitted (Breast or Cervical Diagnostic Enrollment/ Follow Up and Treatment Plan form, Pathology Report, Treatment Funds Request form) by the clinic

Treatment Funds Request Form

Treatment Funds Request Form

Every Woman Matters

NEBRASKA

Version: August 2008

In order for your client to access Medicaid or other treatment resources this form must be complete.

The following documents are required to request financial assistance:

- Treatment Funds Request Form
- Breast/Cervical Diagnostic Enrollment, Follow Up and Treatment Plan
- Pathology Report

For more information see Page 8-1 of the EWM Program Provider Contract Manual

Top two copies go to EWM. Provider may keep the bottom copy.

		EWM Use Only
Treatment Funds Request Form completed by provider on:	Date ____/____/____	☐ Yes/received
Breast/Cervical Diagnostic Enrollment, Follow Up and Treatment Plan completed by provider on:	Date ____/____/____	☐ Yes/received
Pathology Report sent on:	Date ____/____/____	☐ Yes/received

Client Information

First Name	Initial	Last Name	Maiden Name
Birthdate	Social Security #	Home/Cell Phone *circle one* ( )	Work Phone ( )
Address	City	County	State / Zip
In what state was the client born:	Primary Language? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other		

Is the client a U.S. Citizen? ☐ Yes ☐ No

If no, what is the client's immigration status? _____ *(Please attach a copy of the client's INS papers, if available)*

Eligibility:

Medicare:	☐ Yes	☐ No
Medicaid:	☐ Yes	☐ No
Private Insurance:	☐ Yes	☐ No

If yes, list name of insurance company: _____

Diagnostic Test: _____

Diagnostic Test Date: ____/____/____

Result: ☐ CIN I ☐ CIN II ☐ CIN III ☐ Cancer in situ *(breast or cervical)* ☐ Invasive cancer *(breast or cervical)*

Treatment: _____

Scheduled Date: ____/____/____

Performed Date: ____/____/____ *(CANNOT SUBMIT WITHOUT CLIENT ID AND PATHOLOGY REPORT)*

Nebraska Medicaid notifies all clients of acceptance to Medicaid Treatment Funds within three days of receipt of application, along with a copy of Client Rights and Responsibilities.

SURGEON/CLINIC: _____	Phone: (_____)_____
Contact Person: _____	Fax: (_____)_____
HOSPITAL: _____	Phone: (_____)_____
Contact Person: _____	Fax: (_____)_____
PATHOLOGY: _____	Phone: (_____)_____
Contact Person: _____	Fax: (_____)_____
ANESTHESIOLOGY: _____	Phone: (_____)_____
Contact Person: _____	Fax: (_____)_____
Referred By/Clinic: _____	Phone: (_____)_____
Contact Person: _____	Fax: (_____)_____

Attach claim(s) to this form and submit to EWM Staff at the Central Office in Lincoln for clients NOT eligible for Medicaid. Providers have 60 days to submit claims for processing to the EWM Foundation. Treatment funds, if available, are administered through the EWM Foundation.

See reverse of this form for Points of Importance